UNIVERSITY OF TEXAS ARLINGTON

Health Services

Form 9-4
09/14/2011

Consent for Treatment of a Minor Who Does Not Have Legal Power to Consent

Box 19329 605 S. West St. Arlington, TX 76019 T.817.272.2771 F.817.272.3829 www.uta.edu/healthservices

Patient Name: _____

UT Arlington I.D. #: _____

D.O.B.: _____ Gender: _____

Provider: _____ Date: _____

Name of Minor: _____

Date of Birth: _____

Address (Street, City, State, Zip Code):

_____

Parent/Guardian Phone Number: _____ HOME _____ WORK

I, the undersigned as the parent or legal guardian of _____ (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and The University of Texas at Arlington and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

_____ SIGNATURE OR PARENT/LEGAL GUARDIAN

_____ DATE

_____ PRINT NAME

Medical Information Related to Minor:

Allergies: _____

Current Medications: _____

Date of Last Tetanus Booster: _____

Pertinent Medical History: _____

☐ CONDITION WAS URGENT.

Parental/guardian consent for treatment was obtained by telephone from:

_____ NAME OF PARENT/LEGAL GUARDIAN

_____ TIME AND DATE

By _____

UT Arlington Health Services complies with all applicable Texas medical privacy statutes including Occupations Code Chapter 159 and Health & Safety Code Chapter 611 related to information obtained as a result of patient treatment. Health Services will safeguard the privacy and confidentiality of all such information.